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A case of abdominal pregnancy +++

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A CASE OF ABDOMINAL PREGNANCY (EXTRA-UTERINE) OF FIFTY-FIVE YEARS' DURATION.

REPORTED BY J. B. MURFREE, M.D., MURFREESBORO, TENN.

Mrs. Annie M. Wiggs was born in Rutherford County, Tennessee, of healthy parents. She grew up to be a stout and well-developed woman, free from any constitutional vice, either hereditary or acquired. At the age of 21 years she married, and in due course of time became pregnant. Her pregnancy progressed well, with no more inconvenience than is usually experienced by a primipara, save an occasional attack of abdominal pain.

About the end of the eighth or the beginning of the ninth month of gestation, she had what was supposed to be an attack of dysentery, which was violent and protracted. During this illness labor-pains came on, and she, fully expecting to be confined, began to make preparation for that event. Her physician, who livedsome distance from her, was sent for. He came, and remained in constant attendance upon her for forty-eight hours. During this time she suffered with very active labor-pains, and was momentarily expecting to be delivered of her child. This spurious labor was accompanied by a decided vaginal hemorrhage. In the midst of her suffering, the child which she had been carrying, and whose movements heretofore had been strong and frequent, ceased to move, and she felt satisfied that it had died. After three or four days of active labor, the pains diminished in frequency and severity, and finally ceased altogether. This event was followed by a fœtid vaginal discharge that continued for two weeks, perhaps longer, and often contained clots or lumps, which she supposed to be the flesh of the child that was passing off. The dysenteric discharges also gradually disappeared, but she was troubled for a long time with great tenderness over the whole of the abdomen and an occasional violent pain. So intense was this abdominal tenderness that she was unable to lie down in any comfort, and for weeks only slept in a sitting posture.

After a long time of terrible suffering; being very feeble and anæmic,

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the abdominal pain and tenderness subsided, the vaginal discharge ceased, gradually she gained her strength, and once again became a stout woman, but the abdominal tumor remained. Yet, notwithstanding the burden she carried, she was strong and active, doing as much domestic work as any of her neighbors.

About two years after her spurious labor, she again became pregnant, very much to her surprise and alarm, as she knew that she already carried (to use her own expression) the bones of one child. In due course of time she gave birth to a well-developed male child. And while carrying this dead fœtus she bore five children, all of whom are now living, save one.

For the past fifty-four years she has enjoyed good health, and has led an active and laborious life. Aside from the annoyance produced by the mechanical pressure, she has suffered no especial inconvenience from the retained fœtus. Quite a number of years before her death I was allowed to examine her abdomen, and distinctly felt a hard, round tumor, which she insisted was the bones of a dead child, and expressed her determination to carry it with her to the grave.

She died on the 25th of February, 1886, in the 78th year of her age. The next day, with the assistance of Dr. Byrn, I laid open the abdomen and removed an ossified fœtus, being of globular shape, and weighing 3 lbs. 5½ oz., measuring in the longest diameter 19½ inches, in the shortest 15½ inches. The tumor was situated in the abdominal cavity, to the left of the median line, and rested upon the brim of the pelvis, being loosely inclosed in a cyst, which was adherent to the intestines and abdominal wall. The generative organs were so much displaced and atrophied that I failed to recognize their relation to each other.

Extra-uterine pregnancy is not of frequent occurrence by any means, and the rarity of this abnormality will, I trust, suffice for my entering into the details of the subject. Perhaps the majority of physicians pass through a long life of active practice without ever meeting with a case; yet they are frequent enough to possibly occur in the practice of any physician, and we ought to familiarize ourselves with the condition at least sufficiently well as to be able to recognize it when met with. All the text-books on obstetrics devote a chapter to extra-uterine gestation, which, while explicit, is yet very concise. Our medical literature is replete with reports of individual cases, but this erratic phenomena is not discussed at length. The only systematic treatise on extra-uterine pregnancy that I know of is a work by John S. Parry,

of Philadelphia. This volume is thorough and exhaustive, and well worth the studying. From its pages I have gathered much that is here written. Parry collected from various sources five hundred cases, and from an analysis of them and his own observation his work is written.

The cause of extra-uterine pregnancy is by no means definite, and in many cases cannot be determined; yet, on the other hand, there are many pathological conditions occurring in the female organs of generation which are sufficient to account for a misplaced pregnancy. It is a condition that may happen to the young married woman, or to the matron who has passed through several natural labors. Pelvic inflammations, as cellulitis peri and para metritis, may produce such results as will materially interfere with the escape of the fecundated ovum into the uterus by constriction of the fallopian tube, or by the deposition of plastic material which displaces the natural relation of the organs. Not only have these pathological changes been discovered in cases of extra-uterine pregnancy, but the history of the patient has shown that she suffered with a pelvic inflammation at a previous con finement.

Sterility is a condition that very frequently precedes extra uterine conception. The interval between marriage and conception is often quite long, and if the woman has previously borne children there is a pause of several years.

Schrœder says: "For a great number of extra-uterine pregnancies occurred in in primaparæ who had lived for some years in sterile marriage, and also in very many pluriparæ whose extra-uterine pregnancy had been preceded by a long pause in conception."

Uterine displacements, foreign growths, and malformations, by disturbing the anatomical relation of some of the sexual organs or their appendages, act as causes for misplaced pregnancies, and so may a hernia of one of the sexual organs. An unhealed incision of the uterine wall after a Cæsarean section is reported by Lecluyse as having caused it; while M. Koeberle reports a case as taking place after the removal of the body and part of the neck of the uterus, subsequent impregnation taking place through a fistulous opening in the line of the incision This accident in many cases is supposed to be due to mental and moral emotions. Astruc, more than a hundred years ago, asserted that extra-uterine pregnancy was more frequent among widows and unmarried women indulging their passions secretly, yet professing chastity; and later, Ramsbotham favors this opinion. But it is not

borne out by statistics. Hard manual labor and injuries at or near the time of conception are supposed to act as a determining cause. The cases collected by Parry show that misplaced pregnancy occurs most frequently between the ages of twenty and thirty years, and that it is most frequent among women who have borne several children, thus sustaining the opinion that long-continued functional activity of the genital organs and the diseases produced thereby are not without their influence in producing extra-uterine pregnancy.

There are three varieties of extra-uterine pregnancy—the tubal, the ovarian, and the abdominal. Authors subdivide each of these varieties into many species, but for practical purposes it is unnecessary. The name of the form of the pregnancy denotes the locality of the conception. Abdominal pregnancy may be either primary or secondary—*i. e.*, conception may take place directly within the abdomen, or within the ovary or tube, and by rupture subsequently escape into the abdominal cavity. The tubal variety is the most frequent of the varieties, and at the same time the most dangerous.

The pathological appearances presented after death and before rupture of the cyst are in the main similar to those observed in uterine pregnancy. The uterus is increased in size, and its cavity is lined by a soft, pulpy decidua; the cervix contains a gelatinous matter, while all the appendages are unusually vascular. The ovum being arrested in its transit to the uterus, the necessarily increased flow of blood for its nutrition would naturally intensify the hyperæmia at that point, and hence the vascularity of the tubes and ovary is greatly increased, and this fact accounts for the profuse hemorrhage that occurs after rupture of the cyst. "Before the period of quickening death almost always results from rupture of the gravid sac." When this occurs there is a profuse hemorrhage, and the patient dies from the loss of blood and shock. The corpus luteum is found to be the same as in a normal pregnancy, and differs in no particular.

If rupture of the cyst does not occur some time during the first four and a half months of pregnancy, the woman will in all probability go to or near the full term of her gestation. After the completion of term the fœtus will be found enveloped in a cyst and surrounded by the tissues of the neighboring organs.

The placenta is generally attached to the surface of the cavity that contains the fœtus, though not always, for it has been found attached to the mucous membrane of the uterus, while the child was entirely outside of that organ. Whatever may be the situation of the ovum,

it does not present any peculiar or abnormal appearance, but develops physiologically as it would in a natural pregnancy. But its development is not generally so vigorous, although many stout and well developed children are reported as the result of extra uterine pregnancy. The placenta is smaller and less freely supplied with blood-vessels than in uterine pregnancy; the uterus is enlarged and misplaced, being ele vated, and the cervix carried toward or above the pubis. In women who live some length of time after the death of the fœtus, one of two conditions will be found to exist: Either the fætus will have undergone decomposition, or else the liquor amnii being absorbed and the cyst having contracted will remain as a foreign body in a quiescent state, and innocuous. When the fœtus decomposes, the cyst wall inflames, suppurates, and finally forms a fistulous opening into either the bowel, bladder vagina, uterus, or through the external abdominal wall. Through this fistulous tract parts of the decaying fœtus are discharged from time to time. When the child remains as an unirritating foreign body, the cyst undergoes a calcareous or cartilaginous degeneration, and the fœtus becoming ossified is converted into a lithopædion. In other cases the child dries up and becomes mummified; very rarely it is converted into a soft, waxy substance called adipocere, or finally it may remain unchanged for years. The rate of mortality that attends extra-uterine fœtation is estimated at about 68 per cent., and 53 per cent. is due to rupture of the gravid cyst. With such a high rate of mortality the prognosis, under any circumstances, must always be grave. It is more unfavorable in the first four and a half months of gestation than in the latter. At term the prognosis is again more unfavorable, and continues so until the pseudo-puerperal stage is passed and the woman's system recovers from the disturbance through which it has passed. After the death of the fœtus and the restoration of the woman's system to a normal condition, her chances for a long life are greatly enhanced, as the carrying of a child outside of the womb is not incompatible with a long and tolerably comfortable life; but she is always in danger of a fatal accident. The abdominal variety of extra-uterine pregnancy is the most favorable, while the tubal is the most unfavorable. Intra and extra-uterine pregnancy occurring at the same time is not more dangerous than when only one ovum is fecundated and conception takes place outside of the womb.

The symptoms that denote extra-uterine pregnancy are the same as those of normal conception, with the addition of some others that are peculiar to this condition alone. Within the first month there is noth-

ing by which we are enabled to predicate an opinion of misplaced conception; but after this period, in addition to the usual signs of pregnancy, there are certain phenomena that indicate an erratic gestation. These consist of sudden and violent pains in the abdomen, accompanied by very great prostration. These abdominal pains and prostration occur at some period within the first four months, usually about the sixth or eighth week. The pain is sudden, intensely severe, and protracted—it may at first be mistaken for a colic. The first month of pregnancy may have been passed without any departure from the usual train of symptoms, when suddenly and unexpectedly the woman is seized with a most excruciating pain in the abdomen, and the nervous system is depressed to an alarming extent. The skin is bathed in a cold perspiration, the pulse is rapid and feeble, there is nausea, and perhaps vomiting; the condition is one of profound prostration. The pain is in the hypogastrium, rather to one side, and there is more or less tenderness. This condition continues from one to forty-eight hours, gradually passing off for awhile, to return again perhaps with increased violence. These paroxysms recur from time to time, until after the fifth month, when, if the fœtal cyst has not ruptured, they disappear entirely.

Another symptom attending this condition is a vaginal hemorrhage, which is distinguished from the menstrual flow by its irregularity and want of periodicity. It is often accompanied by expulsion of the decidua. Vaginal examination reveals the uterus enlarged, not to the same extent, however, as it would be in a natural pregnancy, and misplaced bya tumor, which can be recognized as distinct from that organ. The tumor fluctuates, and on ballotment a solid body can be detected in it. The breasts undergo the usual development, the abdomen enlarges, mainly, however, on one side, and the transverse diameter is longer often than the perpendicular, and the fœtal mass is less mobile than in uterine pregnancy. The placental murmur and fœtal heart can be distinctly heard, and the probe reveals the uterus empty. Sometimes the fœtus can be felt through the vaginal wall.

When full term is reached the movements of the child are very much increased, and become violent and painful. After awhile they cease altogether, indicating the death of the fœtus. At the end of gestation, usually before, spurious labor sets in, which resembles very much an ordinary labor. The pains are periodical and very much like those of natural labor.

In extra-uterine pregnancy generally, labor comes on prematurely;

in rare cases it has been delayed beyond the normal term. The duration of these pains is uncertain; sometimes they last for several days. They are accompanied by a vaginal hemorrhage and expulsion of the decidua. The fœtal sac is not apt to be ruptured during this false labor. After the death of the child and the termination of the spurious labor the vaginal discharge continues, resembling the lochia. After a few weeks the liquor amnii is absorbed, the cyst contracts, the abdomen is reduced, and the woman regains her strength, and may live many years in tolerable comfort. Nebel had a patient who lived to be over ninety-one years of age, and who had carried the product of a misplaced conception for fifty-five years. But while the presence of an encysted fœtus is not incompatible with a long life of comparative comfort and usefulness, yet the woman who carries such a burden is in constant danger of having lighted up an inflammation that will greatly increase her suffering and probably end her existence. Peritonitis under these circumstances is sometimes conservative in its terminations by attaching the sac to an adjacent organ through which by a fistula the fœtus may escape. Rupture of the cyst at some period of the gestation occurs in about one-half of the cases of misplaced pregnancies, and it is the most terrible accident that can happen to a woman. This calamity is evidenced by violent abdominal pains, metrorrhagia, profound shock, syncope; sometimes convulsions and delirium supervene. The abdomen is distended by effused blood, and the patient may die immediately from the shock and loss of blood, or she may survive for several days and sink from exhaustion. Usually death is rapid and unexpected.

The treatment of extra-uterine pregnancy does not offer much that is encouraging. Opium in large doses to relieve pain is demanded in the early stages. If the diagnosis is clearly determined and the site of the fœtus is recognized, the indication is to destroy its vitality and let it remain as a foreign body. It has been suggested to do this through the system of the mother by starvation, profuse blood-letting, mercurial inunction, the administration of iodide of potash, strychnia, and ergot, the syphilization of the mother; but none of these offer any hope of success. Puncture of the cyst has been done, but unfortunately it has often proved fatal to the mother. Electricity offers the best hope of destroying the ovum, with the least danger to the mother; yet it has failed in some instances to produce the death of the fœtus. Removal of the gravid cyst through an abdominal incision has been proposed, and although an operation attended with great danger, yet

it is justifiable in view of the probability of the woman's life being compromised by a rupture of the cyst.

When rupture of the cyst takes place in the early stages of the pregnancy, gastrotomy may be resorted to as a forlorn hope; but it does offer a hope, and the operation ought to be done.

After the fourth month is passed without rupture of the cyst, the probabilities are that it will not afterward occur, and the only treatment required will be of a palliative character.

After the spurious labor has passed, the patient should be watched with sedulous care, and treated upon the expectant plan, meeting the indications as they may arise. If the patient's life is endangered by exhaustion, peritonitis, septicæmia, or if rupture of the cyst should occur, then gastrotomy should be resorted to at once. Otherwise, nature should be undisturbed, and left to indicate the way in which riddance of the fœtus is to be accomplished. If a fistula should open through the abdominal wall, the orifice should be enlarged, and the child, or its *dèbris*, removed.